	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 44E200	A. BUIL	R) MULTIPLE CONSTRUCTION BUILDING 01 - MAIN BUILDING 01 WING		OMB NO. 0938 (X3) DATE SURVEY COMPLETED	
NAME OF	PROVIDER OR SUPPLIER					06	/04/2012
	BROOK SANITARIU	IM		114 ÇAM	DRESS, CITY, STATE, ZIP CODE PUS DRIVE I, TN 37321		The state of the state of
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{K 000}			{K 000)}			
K 021} SS=D	Sanitarium on June of an Allegation of Correction to remo- cited at K063. The actions implemente the Immediate Jeop Other deficiencies paddressed on the A- remain outstanding submit a plan of cordefeciencies. NFPA 101 LIFE SAI Any door in an exit penclosure, horizonta nazardous area encidevices arranged to doors by zone or thrustivation of: (a) the required manual place of the corder of the	previously cited and not allegation of Compliance. The facility is required to rection for all outstanding of FETY CODE STANDARD passageway, stairway all exit, smoke barrier or losure is held open only by automatically close all such boughout the facility upon all fire alarm system; stors designed to detect got the opening or a required	{K 021}	1) Do close re-test supervidoors doors order a recommendation of the close to the c	or was adjusted on 5/2 to a positive latch. Do not seed by the maintenance or was adjusted on 5/2 to a positive latch. Do not a positive latch. Do not not according to manufact were working proper were verified to be in according to manufact mendations.	cors were that the rly 29/12 to cors were the rely. All working turer	615.11:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2587(02-99) Previous Versions Obsolete

Event ID: G6LS22

Facility ID: TN7201

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If continuation sheet Page 1 of 11

2012-06-07 16:06 DC0547PM13501 8652125642 >> 4237756346 P 106/118 DEPARTMENT OF HEALTH AND HUMAN SERVICES CHRIEN, UDINHIEUIA CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY A. BUILDING COMPLETED 01 - MAIN BUILDING 01 B. WING 44E200 06/04/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE LAURELBROOK SANITARIUM 114 CAMPUS DRIVE DAYTON, TN 37321 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX COMPLETION DATE PREFIX TAG DEFICIENCY) and report on their working order. (K 021) | Continued From page 1 (K 021) Based on observation, the facility failed to assure Exhibit # 52 corridor fire doors will close to a positive latch upon activation of the fire alarm system. The findings include: 4) On 5/31/12 Maintenance Supervisor added to weekly check Observation on May 14, 2012 at 4:05 p.m. list to check all fire doors for revealed the fire doors on the east corridor near operation according to manufacturer patient room one failed to close to a positive latch upon activation of the fire alarm during the fire specifications. This weekly report drill exercise. will be reported quarterly at the QA meeting. Quarterly, the This finding was verified by the maintenance director and acknowledged by the administrator administrator will audit all during the exit conference on May 14, 2012, maintenance log books for accuracy NFPA 101 LIFE SAFETY CODE STANDARD {K 038} and completeness, report to the OA {K 038} SS=D committee, and ultimately to the Exit access is arranged so that exits are readily board of Laurelbrook Sanitarium accessible at all times in accordance with section 7.1. 19.2.1 and School, Inc. This STANDARD is not met as evidenced by: Based on observation, the facility failed to assure fire doors are clear and free from obstructions. The findings include: Observation on May 14, 2012 at 2:47 p.m. revealed the exit passage door leading to the outside of the basement exit way was blocked by a lattes fence and would not open freely. Based on observation, the facility failed to assure exit access is arranged where exits are readily accessible at all times in accordance with 7.1.

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4237756346 P 106/118 DEPARTMENT OF HEALTH AND HUMAN SERVICES FRINTED. UDIVERSULA FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 - MAIN BUILDING 01 B. WING 44E200 06/04/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE LAURELBROOK SANITARIUM 114 CAMPUS DRIVE DAYTON, TN 37321 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PREFIX ID PREFIX PROVIDER'S PLAN OF CORRECTION COMPLETION DATE (EACH CORRECTIVE ACTION SHOULD BE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY (K 021) Continued From page 1 (K 021) Based on observation, the facility failed to assure corridor fire doors will close to a positive latch upon activation of the fire alarm system. The findings include: Observation on May 14, 2012 at 4:05 p.m. revealed the fire doors on the east corridor near patient room one failed to close to a positive latch upon activation of the fire alarm during the fire drill exercise. This finding was verified by the maintenance director and acknowledged by the administrator during the exit conference on May 14, 2012. (K 038) NFPA 101 LIFE SAFETY CODE STANDARD {K 038} K 038 615/12 SS=D Exit access is arranged so that exits are readily 1) Latch on the lattice fence was accessible at all times in accordance with section 7.1. 19.2.1 replaced on 5/30/12. Surface outside of door was replace on 5/30/12 to create the desired surface. 2) Latch on the lattice fence was This STANDARD is not met as evidenced by: replaced on 5/30/12. Surface outside Based on observation, the facility failed to assure of door was replace on 5/30/12 to fire doors are clear and free from obstructions. create the desired surface. The findings include: Observation on May 14, 2012 at 2:47 p.m. 3) Maintenance supervisor will revealed the exit passage door leading to the perform quarterly checks on all outside of the basement exit way was blocked by doors and report on their working a lattes fence and would not open freely. order. Exhibit #49 Based on observation, the facility failed to assure exit access is arranged where exits are readily On 5/31/12 Maintenance accessible at all times in accordance with 7.1,

2012-06-07 16:06 DC0547PM13501 8652125642 >> 4237756346 P 107/118 DEPARTMENT OF HEALTH AND HUMAN SERVICES INITIEL . VUIVALEVIA CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A. BUILDING 01 - MAIN BUILDING 01 B. WING 44E200 06/04/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STAYE, ZIP CODE LAURELBROOK SANITARIUM 114 CAMPUS DRIVE DAYTON, TN 37321 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X5) COMPLETION OATE PREFIX EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Supervisor checked all doors for (K 038) Continued From page 2 (K 038) smooth, hard surface to a safe area, The findings include: and added to quarterly check list to Observation on May 14, 2012 at 2:47 p.m. check all doors for proper operation revealed the exit leading from the basement has and clear of obstructions. Quarterly, no clear, smooth hard surface to a safe area of the administrator will audit all refuge. maintenance log books for accuracy and completeness, report to the QA These findings were verified by the maintenance committee, and ultimately to the director and acknowledged by the administrator board of Laurelbrook Sanitarium during the exit conference on May 14, 2012. and School, Inc. NFPA 101 LIFE SAFETY CODE STANDARD (K 050) {K 050} SS=F Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on observation, the facility failed to assure staff members are familiar with proper fire drill procedures. The findings include: Observation during a fire drill conducted on May 14, 2012 at 4;10 p.m. revealed the person discovering the fire was not familiar with the proper fire drill policies and was instructed by the administrator of the proper procedures. Further observations revealed staff members moving

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL	ILTIPLE CONSTRUCTION DING 01 - MAIN BUILDING 01	(X3) DATE S COMPL	
MANE OF	2000/1000 40 00000	44E200	B. VVINC	3	06/0	4/2012
	PROVIDER OR SUPPLIER BROOK SANITARIUM			STREET ADDRESS, CITY, STATE, ZIP CODE 114 CAMPUS DRIVE DAYTON, TN 37321		
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K 038} SS=D	Based on observation corridor fire doors with upon activation of the The findings include: Observation on May revealed the fire doo patient room one fail upon activation of the drill exercise. This finding was verified in the director and acknowled during the exit conferior NFPA 101 LIFE SAFI	on, the facility failed to assure ill close to a positive latch e fire alarm system.	{K 038		outside	6/5 12
fi fi T	Based on observation re doors are clear an he findings include; because 1 and 1 average 1 are the exit passing the exit passing 1 are the	ot met as evidenced by: t, the facility failed to assure of free from obstructions. 4, 2012 at 2:47 p.m. age door leading to the ont exit way was blocked by		2) Latch on the lattice fence we replaced on 5/30/12. Surface of door was replace on 5/30/1 create the desired surface. 3) Maintenance supervisor will perform quarterly checks on a supervisor will perform quarterly will perform quarterly will perform	outside 2 to	
B ex	lattes fence and wou ased on observation, kit access is arranged	the facility failed to assure where exits are readily in accordance with 7.1,		doors and report on their work order. Exhibit # 49 4) On 5/31/12 Maintenance	ing	

2012-06-07 16:06 DC0547PM13501 8652125642 >> 4237756346 P 107/118 DEPARTMENT OF HEALTH AND HUMAN SERVICES FINITIEN, WOWNESULE CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING COMPLETED 01 - MAIN BUILDING 01 B. WING 44E200 NAME OF PROVIDER OR SUPPLIER 06/04/2012 STREET ADDRESS, CITY, STATE, ZIP CODE LAURELBROOK SANITARIUM 114 CAMPUS DRIVE **DAYTON, TN 37321** (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLETION OATE PREFIX TAG TAG DEFICIENCY) Supervisor checked all doors for {K 038} Continued From page 2 {K 038} smooth, hard surface to a safe area, The findings include: and added to quarterly check list to Observation on May 14, 2012 at 2:47 p.m. check all doors for proper operation revealed the exit leading from the basement has and clear of obstructions. Quarterly, no clear, smooth hard surface to a safe area of the administrator will audit all refuge. maintenance log books for accuracy and completeness, report to the OA These findings were verified by the maintenance committee, and ultimately to the director and acknowledged by the administrator board of Laurelbrook Sanitarium during the exit conference on May 14, 2012. and School, Inc. (K 050) NFPA 101 LIFE SAFETY CODE STANDARD (K 050) SS=F Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on observation, the facility failed to assure staff members are familiar with proper fire drill procedures. The findings include: Observation during a fire drill conducted on May 14, 2012 at 4:10 p.m. revealed the person discovering the fire was not familiar with the proper fire drill policies and was instructed by the administrator of the proper procedures. Further observations revealed staff members moving

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4237756346 P 107/118 DEPARTMENT OF HEALTH AND HUMAN SERVICES רואויובט, טטוטיובטוב CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING COMPLETED 01 - MAIN BUILDING 01 8. WING 44E200 NAME OF PROVIDER OR SUPPLIER 06/04/2012 STREET ADDRESS, CITY, STATE, ZIP CODE LAURELBROOK SANITARIUM 114 CAMPUS DRIVE DAYTON, TN 37321 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE ACH DEFICIENCY MUST BE PRECEDED BY FULL ID (X5) COMPLETION DATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) (K 038) Continued From page 2 (K 038) The findings include: Observation on May 14, 2012 at 2:47 p.m. revealed the exit leading from the basement has no clear, smooth hard surface to a safe area of refuge. These findings were verified by the maintenance director and acknowledged by the administrator during the exit conference on May 14, 2012. 6/5/12 K 050 NFPA 101 LIFE SAFETY CODE STANDARD (K 050) (K 050) SS=F Fire drills are held at unexpected times under 1) In-services on fire drill varying conditions, at least quarterly on each shift. procedures for all staff were The staff is famillar with procedures and is aware conducted 5/28/12 to 5/30/12. An that drills are part of established routine. unexpected fire drill was conducted Responsibility for planning and conducting drills is assigned only to competent persons who are on 6/1/12 to verify staff qualified to exercise leadership. Where drills are understanding of proper fire drill conducted between 9 PM and 6 AM a coded procedures. announcement may be used instead of audible alarms. 19.7.1.2 2) Fire drills and follow-up inservice will be conducted on a weekly basis for four weeks during This STANDARD is not met as evidenced by: the month of June. Following this, Based on observation, the facility failed to assure staff members are familiar with proper fire drill we will do monthly fire drills as procedures. required. Maintenance supervisor The findings include: will be responsible for in-servicing all personnel and performing Observation during a fire drill conducted on May required fire drills and 14, 2012 at 4:10 p.m. revealed the person discovering the fire was not familiar with the documentation. proper fire drill policies and was instructed by the administrator of the proper procedures. Further 3) Fire drills and follow-up inobservations revealed staff members moving

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/07/2012 FORM APPROVED OMB NO. 0938-0391

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	ROVIDER OR SUPPLIE	ER		S	TREET ADDRESS, CITY, STATE, ZIF	CODE 06	/05/2012
	OOK SANITARIUM				114 CAMPUS DRIVE DAYTON, TN 37321		
(X4) ID PREFIX TAG	SUMMARY STATE	EMENT OF DEFFICIENCIES	ID PREF TAG		PROVIDERS PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
			K 050		service will be conducted weekly basis for four we the month of June. Follow we will do monthly fire of required. Maintenance su will be responsible for in all personnel and perform required fire drills and documentation. 4) Fire drills and in-service documentation will be ke maintenance Supervisor at Quarterly, the administrate audit all maintenance log accuracy and completeness to the QA committee, and to the board of Laurelbrook Sanitarium and School, In Ext	eks during wing this, irills as pervisor servicing ing	
BORATORY DIREC	CTOR'S OR PROVIDER/SUPP	PLIER REPRESENTATIVE'S SIGNATURE			TITLE	444	(X6) DATE

2012-06-07 16:07 DC0547PM13501 8652125642 >> 4237756346 P 108/118 DEPARTMENT OF HEALTH AND HUMAN SERVICES INTITLE WILLIAMIENTE CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY COMPLETED A. BUILDING 01 - MAIN BUILDING 01 B. WING 44E200 06/04/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE LAURELBROOK SANITARIUM 114 CAMPUS DRIVE DAYTON, TN 37321 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION PREFIX (X5) COMPLETION DATE PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) (K 050) Continued From page 3 {K 050} patients from the front lobby and placing them in the west wing corridor for safety. This finding was verified by the maintenance director and acknowledged by the administrator during the exit conference on May 14, 2012. (K 051) NFPA 101 LIFE SAFETY CODE STANDARD (K 051) SS=D A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6 This STANDARD is not met as evidenced by: Based on observation, the facility failed to assure

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4237756346 P 108/118 DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER COMPLETED A. BUILDING 01 - MAIN BUILDING Q1 B. WING 44E200 06/04/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE LAURELBROOK SANITARIUM 114 CAMPUS DRIVE **DAYTON, TN 37321** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION) PREFIX (X5) COMPLETION DATE PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (K 050) Continued From page 3 {K 050} patients from the front lobby and placing them in the west wing corridor for safety. This finding was verified by the maintenance director and acknowledged by the administrator during the exit conference on May 14, 2012. (K 051) NFPA 101 LIFE SAFETY CODE STANDARD K 051 (K 051) 6/512 SS=D A fire alarm system with approved components, 1) Building Systems Technology, devices or equipment is installed according to Inc. on 6/1/12 added a pull station in NFPA 72, National Fire Alarm Code, to provide the laundry room by the exit door. effective warning of fire in any part of the building. Activation of the complete fire alarm system is by On the same date, BST put a control manual fire alarm initiation, automatic detection or relay on the outside gate to unlock extinguishing system operation. Pull stations in the maglock upon activation of the patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of fire alarm system, and tested all nurse's stations. Pull stations are located in the components according to the fire path of egress. Electronic or written records of safety report. tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and 2) Building Systems Technology, records of maintenance are kept readily available. Inc. on 6/1/12 added a pull station in There is remote annunciation of the fire alarm the laundry room by the exit door. system to an approved central station. On the same date, BST put a control 9.6 relay on the outside gate to unlock the maglock, and tested all components according to the fire safety report. 3) The maintenance supervisor will be responsible to verify operation of all fire doors and gate on the same This STANDARD is not met as evidenced by: date when a fire drill is done, and Based on observation, the facility failed to assure

ND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	LTIPLE CONSTRUCTION DING 01 - MAIN BUILDING 01	(X3) DATE :	O. 0938-03 SURVEY LETED
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the manual fire five (5) feet fro The findings in	, i i i i i i i i i i i i i	pull station is located within	{K 051	document their proper operation. The maintenance supervisor instruct all fire alarm contrathat pull stations must be in	will ctors stalled	
1	room and was not act the laundry to the out the laundry to the out the fire alarm system locking hardware device. Observation on May 1 revealed the courtyard hardware device that contract the fired and the courty and hardware device that contract the courty and hardware device that contract the courty and hardware device that courty and hardware device that courty and the courty	fire alarm pull station in the lated in the center of the cessible to the staff exiting side at the exit door. In the facility failed to assure released all approved ices in the path of egress. 4, 2012 at 4:10 p.m.		4) Fire safety documentation including proper operation of doors and fire gates will be the maintenance Supervisor required. Quarterly, the administrator will audit all maintenance log books for a and completeness, report to committee, and ultimately to board of Laurelbrook Sanita and School, Inc.	of fire kept by as couracy the QA the	
052} N S=D A in w 72	fire alarm system requistalled, tested, and maith NFPA 70 National 2. The system has an	uired for life safety is aintained in accordance Electrical Code and NFPA approved maintenance	{K 052}	Exhib	it # 50	

STATEME	NT OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/SLIA IDENTIFICATION NUMBER:	100	ULTIPLE CONSTRUCTION LDING 01 - MAIN BUILDING 01	(X3) DATE	RM APPROV IO. 0938-03 SURVEY PLEYED
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	the manual fire alarm five (5) feet from the The findings include: Observation on May revealed the manual laundry room was loc room and was not ac the laundry to the out Based on observation the fire alarm system locking hardware device. Observation on May 1 revealed the courtyarchardware device that of the fire alarm system locking hardware device that the fir	n pull station is located within exit door. 14, 2012 at 3:00 p.m. fire alarm pull station in the rated in the center of the cessible to the staff exiting side at the exit door. 1, the facility failed to assure released all approved ices in the path of egress. 4, 2012 at 4:10 p.m.	{K 05	13		
052} N SS=D A ir w 7	furing the exit conferent furing the exit conferent furing the exit conferent furing the safe of the system reconstalled, tested, and movith NFPA 70 National 2. The system has an	IY CODE STANDARD puired for life safety is aintained in accordance Electrical Code and NFPA approved maintenance mplying with applicable	{K 052}	1) Fire alarm tests are con- Building Systems Technol the documentation is inclu- this deficiency. Document now be kept with other fire documentation with the maintenance supervisor, as with the administrator. Inc with the deficiency respon- tests from 2/29/12, 8/2/11, 2/15/11 and 8/24/10.	ducted by logy, and ded with ation will end a copy cluded se are the	615./12

ND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL B. WIN	THE WATER PORTOR	(X3) DATE COMPI	0. 0938-03 SURVEY ETED R
AME OF	PROVIDER OR SUPPLIER	44E200	D. *****		06/	04/2012
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K 052}	,	not met as evidenced by:	{K 05	Building Systems Technology the documentation is included this deficiency. Documentation	ogy, and led with tion will	
	the fire alarm system safety of the resident: The findings include: Observation and interdirector, on May 14, 2	in, the facility failed to assure is maintained to ensure the s. view with the maintenance to 12 at 5:15 p.m. revealed the fire alarm system was		now be kept with other fire documentation with the maintenance supervisor, an with the administrator. Inc. with the deficiency respons tests from 2/29/12, 8/2/11, a 2/15/11 and 8/24/10.	d a copy luded e are the and	
K 054} N SS=F	NEPA 101 LIFE SAFE All required smoke detactivating door hold-op	ry CODE STANDARD ectors, including those and devices, are approved, and tested in accordance	{K 054}	3) Documents will be kept in the maintenance supervisor's log book as well as with the administrator. 4) Documentation will be kept by the maintenance Supervisor as required. Quarterly, the administrator will audit all maintenance log books for accuracy and completeness, report to the QA	kept by as	
ar sr tw	sased on interview with not record review, the t	ot met as evidenced by: h maintenance director facility failed to assure tested for sensitivity every		committee, and ultimately to board of Laurelbrook Sanita and School, Inc.	the	

2012-06-07 16:07 DC0547PM13501 8652125642 >> 4237756346 P 110/118 DEFARTIVIEW OF MEALIH AND HUMAN SERVICES HITTLE WINTENIA FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 - MAIN BUILDING 01 B. WING 44E200 06/04/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 114 CAMPUS DRIVE LAURELBROOK SANITARIUM **DAYYON, TN 37321** SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE ID PREFIX PREFIX (X5) COMPLETION DATE TAG TAG DEFICIENCY (K 052) Continued From page 5 (K 052) This STANDARD is not met as evidenced by: Based on observation, the facility failed to assure the fire alarm system is maintained to ensure the safety of the residents. The findings include: Observation and interview with the maintenance director, on May 14, 2012 at 5:15 p.m. revealed no documentation for the fire alarm system was available at this time for the inspection. This finding was verified by the maintenance director and acknowledged by the administrator during the exit conference on May 14, 2012. K 054 6/5/12 (K 054) NFPA 101 LIFE SAFETY CODE STANDARD {K 054} SS=F 1) Smoke detector tests are All required smoke detectors, including those conducted by Building Systems activating door hold-open devices, are approved. maintained, inspected and tested in accordance Technology, and the documentation with the manufacturer's specifications. 9.6.1.3 is included with our response to this deficiency. Documentation will now be kept with other fire This STANDARD is not met as evidenced by: documentation with the Based on interview with maintenance director maintenance supervisor, and a copy and record review, the facility failed to assure with the administrator smoke detectors were tested for sensitivity every two (2) years. 2) Smoke detector tests are The findings include: conducted by Building Systems Observation and interview with maintenance Technology, and the documentation director on May 14, 2012 at 5:46 p.m. revealed is included with our response to this the facility failed to provide documentation that a

2012-06-07 16:07 DC0547PM13501 8652125642 >> 4237756346 P 111/118 DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED 01 - MAIN BUILDING 01 B. WING 44E200 06/04/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE LAURELBROOK SANITARIUM 114 CAMPUS DRIVE DAYTON, TN 37321 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (X5) COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG TAG DEFICIENCY deficiency. Documentation will now {K 054} Continued From page 6 (K 054) two (2) year sensitivity test was performed on the be kept with other fire fire alarm smoke detectors within the facility. documentation with the maintenance supervisor, and a copy with the administrator. This finding was verified by the maintenance director and acknowledged by the administrator 3) Documents will be kept in the during the exit conference on May 14, 2012. {K 062} NFPA 101 LIFE SAFETY CODE STANDARD maintenance supervisor's log book, (K 062) SS=D as well as with the administrator. Required automatic sprinkler systems are continuously maintained in reliable operating 4) Documentation will be kept by condition and are inspected and tested the maintenance Supervisor as periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 required. Quarterly, the administrator will audit all maintenance log books for accuracy and completeness, report to the QA This STANDARD is not met as evidenced by: Based on observation, the facility failed to assure committee, and ultimately to the the sprinkler system was maintained. board of Laurelbrook Sanitarium The findings include: and School, Inc. Observation on May 14, 2012 at 2:35 p.m. revealed one (1) of five (5) sprinkler heads in the Exhibit #51 kitchen near the hood area had a heavy build up of grease and dirt. Observation on May 14, 2012 at 4:48 p.m. revealed the facility failed to provide a weekly fire pump log performed by staff maintenance personnel. Observation on May 14, 2012 at 2:40 p.m. revealed numerous areas in the basement had wiring supported by the sprinkler piping. These findings were verified by the maintenance director and acknowledged by the administrator during the exit conference on May 14, 2012.

8652125642 >> 4237756346 P 111/118 DEPARTMENT OF HEALTH AND HUMAN SERVICES WILL. DUIVALENTE CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01 B. WING 44E200 06/04/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE LAURELBROOK SANITARIUM 114 CAMPUS DRIVE **DAYTON, TN 37321** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (X5) COMPLETION DATE PREFIX TAG TAG DEFICIENCY) (K 054) Continued From page 6 (K 054) two (2) year sensitivity test was performed on the fire alarm smoke detectors within the facility. This finding was verified by the maintenance director and acknowledged by the administrator during the exit conference on May 14, 2012. {K 062} K 062 NFPA 101 LIFE SAFETY CODE STANDARD {K 062} 6/5/12 SS=D Required automatic sprinkler systems are 1) Smoke detector tests are continuously maintained in reliable operating conducted by Building Systems condition and are inspected and tested Technology, and the documentation periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9,7.5 is included with our response to this deficiency. Documentation will now be kept with other fire This STANDARD is not met as evidenced by: documentation with the Based on observation, the facility failed to assure maintenance supervisor, and a copy the sprinkler system was maintained. with the administrator. The findings include: 2) Smoke detector tests are Observation on May 14, 2012 at 2:35 p.m. revealed one (1) of five (5) sprinkler heads in the conducted by Building Systems kitchen near the hood area had a heavy build up Technology, and the documentation of grease and dirt. is included with our response to this 2. Observation on May 14, 2012 at 4:48 p.m. deficiency. Documentation will now revealed the facility failed to provide a weekly fire pump log performed by staff maintenance be kept with other fire personnel. documentation with the Observation on May 14, 2012 at 2:40 p.m. maintenance supervisor, and a copy revealed numerous areas in the basement had with the administrator. wiring supported by the sprinkler piping. 3) Documents will be kept in the These findings were verified by the maintenance maintenance supervisor's log book, director and acknowledged by the administrator as well as with the administrator during the exit conference on May 14, 2012.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/07/2012 FORM APPROVED

OMB NO 0938-0391

AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMB	I		MULTIPLE ONSTRUCTION	(X3) DATE	E SURVEY
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	ROVIDER OR SUPPLI	ER		T	STREET ADDRESS, CITY, STATE, Z	IP CODE	/05/2012
LAURELBR	OOK SANITARIUM				114 CAMPUS DRIVE DAYTON, TN 37321	_	
(X4) ID PREFIX TAG	SUMMARY STATE	EMENT OF DEFFICIENCIES	PREI TAG	FIX	PROVIDERS PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	I SHOULD BE	(X5) COMPLETIO DATE
ORATORY DIRE	CTOR'S OR PROVIDER/SUPP	PLIER REPRESENTATIVE'S SIGNATURE	K 062			all for accuracy t to the QA ly to the	(X6) DATE

4237756346 P 112/118 8652125642 >> DC0547PM13501 2012-06-07 16:08 FRIINIEN: DOIDAIAUTA DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 - MAIN BUILDING 01 B. WING 44E200 06/04/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 114 CAMPUS DRIVE LAURELBROOK SANITARIUM DAYTON, TN 37321 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG DEFICIENCY K 064 NFPA 101 LIFE SAFETY CODE STANDARD {K 064} (K 064) 6/5/12 SS=D 1) On 5/31/12 Chattanooga Fire Portable fire extinguishers are provided in all Protection relocated K-Class fire health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 extinguisher in the kitchen. 2) Starting 5/31/12 the Dietery Manager will in-service all staff regarding space requirements for fire safety equipment. This STANDARD is not met as evidenced by: 3) Starting 5/31/12 the Based on observation, the facility failed to assure maintenance department, during fire extinguishers complied with the requirements monthly fire extinguisher checks, of NFPA 10. will make sure that nothing is The findings include: blocking them. The maintence Observation on May 14, 2012 at 2:30 p.m. department staff have been inrevealed the K class fire extinguisher located in serviced on this procedure on the kitchen was blocked by a metal serving table. 6/1/12. Exhibit #55 This finding was verified by the maintenance 4) Starting 6/1/12 the Maintenance director and acknowledged by the administrator Supervisor will report a list of any during the exit conference on May 14, 2012. fire extinguisher problems to the (K 067) NFPA 101 LIFE SAFETY CODE STANDARD (K 067) QAPI Committee quarterly and SS=F Heating, ventilating, and air conditioning comply ultimately the Administrator will with the provisions of section 9.2 and are installed report to the Board Quarterly. in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility falled to assure fire dampers were maintained in accordance with NFPA 90A.

STATE	MENT OF DEFICIENCIES	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	lova Le	THE TOTAL CONTRACTOR	OMB N	M APPRO O. 0938-0
AND PL	AN OF CORRECTION	IDENTIFICATION NUMBER:	01 (0.00)	ULTIPLE CONSTRUCTION LDING 01 - MAIN BUILDING 01	(X3) DATE	SURVEY
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NAME	OF PROVIDER OR SUPPLIER	426		STREET ADDRESS, CITY, STATE, ZIP CO	06	04/2012
	ELBROOK SANITARIUI			114 CAMPUS DRIVE DAYTON, TN 37321	DE	
(X4) I PREF TAG	IX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFID TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD DE	(X5) COMPLETI DATE
{K 06-	Portable fire extings	FETY CODE STANDARD uishers are provided in all notes in accordance with NFPA 10	{K 06	4}	Dillhamman	
1	fire extinguishers co of NFPA 10. The findings include: Observation on May revealed the K class the kitchen was block. This finding was verification and acknowled during the exit conference NFPA 101 LIFE SAFE Heating, ventilating, a with the provisions of in accordance with the specifications. 19.5.2.2 This STANDARD is not based on observation.	14, 2012 at 2:30 p.m. fire extinguisher located in sed by a metal serving table. ied by the maintenance edged by the administrator ence on May 14, 2012, ETY CODE STANDARD and air conditioning comply section 9.2 and are installed.	{K 067}	K 067 1) On 5/31/12 Goins Hear Conditioning checked dann the every four year requires maintenance. Ventilator flow fans have installed on 6/1/12 in clear storage areas in the basemmaintenance staff	ting & Air nper for ed been n linen	6/5/12

2012-06-07 16:08 DC0547PM13501 8652125642 >> 4237756346 P 113/118 DEPARTMENT OF HEALTH AND HUMAN SERVICES CUINTED. DOIVHIENTE CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 - MAIN BUILDING 01 B. WING 44E200 NAME OF PROVIDER OR SUPPLIER 06/04/2012 STREET ADDRESS, CITY, STATE, ZIP CODE LAURELBROOK SANITARIUM 114 CAMPUS DRIVE DAYTON, TN 37321 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEPICIENCY) (EACH DEFICIENCY MUST BE PRECEDED BY FULL (XS) PREFIX TAG TAG REGULATORY OR LSC IDENTIFYING INFORMATION) BATE {K 067} Floor heater cover has been Continued From page 8 {K 067} replaced in patient room 1 by The findings include: maintenance staff on 5/31/12. Record review and interview with the maintenance director on May 14, 2012 at 5:30 p.m. confirmed the facility falled to perform the 2) On 5/31/12 the maintenance 4-year required maintenance to fire dampers. Supervisor checked all rooms for Based on observation, the facility failed to assure missing covers on heating coils. the proper air flow is maintained throughout the building. The findings include: 3) On 6/1/12 the Maintenance Supervisor will start doing a Observation on May 14, 2012 at 2:50 p.m. revealed the three (3) clean linen storage areas in Room/Bath/Equipment Fall Risk the basement has no positive air flow installed. Assessment Form. This form will be completed on a quarterly basis. Based on observation, the facility failed to assure the HVAC system is maintained in accordance to Exhibit #57 the manufacturer's specifications. The findings include: 4) Starting 6/1/12 the Maintenance Supervisor will report a list of room Observation on May 14, 2012 at 3:52 p.m. repairs done or in process to the new revealed the installed floor heater in patient room one has no protective cover and the heating coils QAPI Committee on a quarterly were exposed. basis and ultimately the Administrator will report to the Board Quarterly. These findings were verified by the maintenance director and acknowledged by the administrator during the exit conference on May 14, 2012. {K 144} NFPA 101 LIFE SAFETY CODE STANDARD {K 144} SS=D Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.

2012-06-07 16:08 DC0547PM13501 8652125642 >> 4237756346 P 113/118 DEPARTMENT OF HEALTH AND HUMAN SERVICES FRIITIEN. UDIVAICUIC CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A. BUILDING 01 - MAIN BUILDING 01 44E200 B. WING NAME OF PROVIDER OR SUPPLIER 06/04/2012 STREET ADDRESS, CITY, STATE, ZIP CODE LAURELBROOK SANITARIUM 114 CAMPUS DRIVE DAYTON, TN 37321 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX (X5) COMPLETION DATE TAG TAG DEFICIENCY) (K 067) | Continued From page 8 {K 067} The findings include: Record review and interview with the maintenance director on May 14, 2012 at 5:30 p.m. confirmed the facility failed to perform the 4-year required maintenance to fire dampers. Based on observation, the facility failed to assure the proper air flow is maintained throughout the building. The findings include: Observation on May 14, 2012 at 2:50 p.m. revealed the three (3) clean linen storage areas in the basement has no positive air flow installed. Based on observation, the facility failed to assure the HVAC system is maintained in accordance to the manufacturer's specifications. The findings include: Observation on May 14, 2012 at 3:52 p.m. revealed the installed floor heater in patient room one has no protective cover and the heating coils were exposed. These findings were verified by the maintenance director and acknowledged by the administrator during the exit conference on May 14, 2012. K 144 (K 144) NFPA 101 LIFE SAFETY CODE STANDARD 6/5/12 {K 144} SS=D 1) On 5/31/12 maintenance staff Generators are inspected weekly and exercised installed emergency lighting in the under load for 30 minutes per month in accordance with NFPA 99. generator area.

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 44E200	(X2) MUL A. BUILDI B. WING	TI MINING DOLLOWING OF	(X3) DATE COMPI		
LAUREL	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 114 CAMPUS DRIVE DAYTON, TN 37321			
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(K 144)	Continued From pag	ge 9	(K 144)	2) On 5/31/12 maintenance checked emergency lighting generator for operation.			
K 147) SS=D	Based on observation the emergency gene battery-powered emergency gene battery-powered emergency for the findings include: Observation on May confirmed the emergency for the	14, 2012 at 4:10 p.m. ency generator location was tery-powered emergency ied by the maintenance edged by the administrator ence on May 14, 2012, ETY CODE STANDARD equipment is in accordance hal Electrical Code, 9.1,2 not met as evidenced by: h, the facility failed to assure alled in accordance with 4, 2012 at 2:45 p.m. fical junction boxes in the ned low-voltage wiring has	{K 147}	3) Starting 5/31/12 the Maintenance Supervisor wi all inspection reports for life to the QAPI committee for the QAPI committee for the Maintenance Supervisor with any recommendations from safety inspector to the new Committee on a quarterly builtimately the Administrator report to the Board Quarterly	e safety review. Il report life QAPI asis and		

TATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	ILTIPLE CONSTRUCTION DING 01 - MAIN BUILDING 01	(X3) DATE:	0. 0838-039 SURVEY ETED
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	PROVIDER OR SUPPLIER BROOK SANITARIUM	Л		STREET ADDRESS, CITY, STATE, ZIP CODE 114 CAMPUS DRIVE	1 06/	04/2012
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	p.m. confirmed the 4-year required main Based on observation the proper air flow is building. The findings include Observation on May revealed the three (3 the basement has no Based on observation of the basement has no Based on observation of the basement has no based on observation the basement has no based on observation of the based on observation the based on obse	interview with the proof on May 14, 2012 at 5:30 facility failed to perform the intenance to fire dampers. On, the facility failed to assure is maintained throughout the second throughout throughout the second throughout	{K 067	7}		
(144) SS=D	the HVAC system is the manufacturer's The findings include: Observation on May revealed the installed one has no protective were exposed. These findings were lirector and acknowled the exit confering t	maintained in accordance to specifications. 14, 2012 at 3:52 p.m. If floor heater in patient room e cover and the heating coils verified by the maintenance edged by the administrator ence on May 14, 2012. ETY CODE STANDARD cted weekly and exercised utes per month in	{K 144}	K 144 1) On 5/31/12 maintenance installed emergency lighting generator area.	e staff	615112

STATEMEN	Y OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD B. WING	VI MININ DOLDING VI	(X3) DATE S	0.0938-039 BURVEY ETED R
	PROVIDER OR SUPPLIER	44E200	s	TREET ADDRESS, CITY, STATE, ZIP CODE 114 CAMPUS DRIVE DAYTON, TN 37321	06/0	4/2012
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{K 144}	Continued From page	ge 9	{K 144	2) On 5/31/12 maintenance checked emergency lighting generator for operation.		10000
(K 147) SS=D	Based on observation the emergency general battery-powered em The findings include Observation on May confirmed the emergency provided with ballighting. This finding was verification and acknowled during the exit conference of t	fied by the maintenance ledged by the administrator rence on May 14, 2012. ETY CODE STANDARD equipment is in accordance anal Electrical Code, 9.1.2 not met as evidenced by: In, the facility failed to assure stalled in accordance with	{K 147}	3) Starting 5/31/12 the Maintenance Supervisor wil all inspection reports for life to the QAPI committee for r. 4)) Starting 6/1/12 the Maintenance Supervisor will any recommendations from safety inspector to the new Committee on a quarterly baultimately the Administrator report to the Board Quarterly	safety eview. I report life (API sis and will	

STATEME	NY OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD B. WING	VI HIMIN DUILDING VI	(X3) DATE	O. 0938-0 SURVEY LETED
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(K 144)	Continued From pag	ge 9	{K 144		And the second s	
	Based on observation the emergency gene battery-powered emergency include: Observation on May confirmed the emergency	not met as evidenced by: on the facility failed to provide rator panel control room with ergency lighting. 14, 2012 at 4:10 p.m. ency generator location was tery-powered emergency	·			
147) SS=D	director and acknowled during the exit conference NFPA 101 LIFE SAFE	ed by the maintenance edged by the administrator ence on May 14, 2012. ETY CODE STANDARD equipment is in accordance all Electrical Code, 9,1.2	{K 147}	K 147 1) Electrical junction boxes basement had their covers repon 5/15/12 by Maintenance Supervisor.		6/5/1
e N T	Based on observation electrical wiring is instance in the findings include: Observation on May 1-avealed two (2) electrical in the findings include:	ical junction boxes in the ned low-voltage wiring has		 2) On 5/16/12 the Maintenar Supervisor checked all basem and resident care areas for an junction box missing a cover replaced any that were missing 3) On 5/31/12 checked facility missing junction boxes cover. 	and eg.	

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STATEMEN	ERS FOR MEDICARE & MEDICAID SERVICES NT OF DEFICIENCIES OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 44E200		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING		FORM APPROVE OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED R 06/04/2012	
	PROVIDER OR SUPPLIER BROOK SANITARIUN		- 1	REET ADDRESS, CITY, SYATE, ZIP CODE 114 CAMPUS DRIVE DAYTON, TN 37321	THE PERSON NAMED IN COLUMN TWO IS NOT THE OWNER.	0402012
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	COMPLETION DATE
(K 147)	director and acknow	ge 10 ified by the maintenance dedged by the administrator erence on May 14, 2012.	{K 147}		ibit # 53 intenance t of any ts to the and or will	